Reset a Form

APPLICATION FOR APPROVAL TO PROVIDE CATEGORY I CONTINUING EDUCATION FOR LSW / LCSW / LMFT / LMHC

State Form 50841 (R2 / 3-06)

Approved by State Board of Accounts, 2006

SOCIAL WORKER, MARRIAGE AND FAMILY THERAPIST AND MENTAL HEALTH COUNSELOR BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2064
E-mail: pla5@pla.IN.gov

FOR OFFICE USE ONLY		
Fee amount	Date fee paid (*month, day, year*)	Receipt number
Reviewed by	Date registration issued (*month, day, year*)	Registration number issued

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of organization			Daytime telephone number ( )
Address (*number and street*)	City	State	ZIP code
Contact person	E-mail address	Web address	

APPLYING TO BE A PROVIDER FOR WHICH TYPE(S) OF LICENSE(S)

This board licenses four (4) different professionals. Note that our form asks you which of those you wish to include in your CE presentations for credit. Please check each of the professionals whom you plan to include.

☐ Social Worker (LSW)	☐ Clinical Social Worker (LCSW)
☐ Marriage and Family Therapist (LMFT)	☐ Mental Health Counselor (LMHC)

TYPE(S) OF CONTINUING EDUCATION PROGRAMS TO BE PRESENTED

☐ Formally Organized Courses	☐ Symposia	☐ Workshops
☐ Institutes	☐ Seminars	☐ Other

SUBMIT THE FOLLOWING INFORMATION WITH YOUR APPLICATION

Note: The questions below generally assume that this application is from an organization. If you are an individual seeking approval to provide Continuing Education, please answer the following questions as if you are the "organization" to which any question refers. If additional space is needed, please attach a separate sheet of paper.

1. **Statement of Objectives:** Each Continuing Education (CE) presentation should have two or more learning objectives and these should be made known to potential attendees in your presentation announcement. How is your organization going to meet this requirement?

2. Learning Objectives: Do you have learning objectives for your overall educational program? ☐ Yes ☐ No
If your answer is "yes", what are they?

3. Responsible Person for Education: Who within your organization will be developing and implementing your educational program? What are the credentials of this person/these people?

4. Maintenance of Records: We require that you keep records of the presentations your organization makes and of the attendees for a minimum of six (6) years. How do you propose to accomplish this?

5. Adequate funding: How will your educational programs be financed?

6. Curriculum: It is required that each presentation explore one subject or a closely related group of subjects in sufficient depth to be meaningful to professional attendees. What topic(s) does your organization propose to teach within its CE program(s) and/or how will they be selected?

7. **Previous Programs:** Have you already presented a seminar/workshop/training on this topic(s)? If so, where and when?

8. **Faculty:** How does your organization plan to select and credential CE presenters?

9. **Facilities:** It is required that CE be given in an environment conducive to adult learning. Where do you anticipate that your organization's CE will be presented and what will the presentation rooms be like?

10. **Educational Methods and Aids:** Do you anticipate that your organization's educational presentations will be lectures, seminars, demonstrations, or something else entirely? Will there be audio-visual aids? Will a syllabus be available to attendees?

11. **Program Evaluation:** It is required that some sort of tool is available to program attendees, in which they can measure the quality and effectiveness of the CE program(s). How will your organization ensure program evaluation is adequate? If you have already created an evaluation form, please attach that form to this application.

12. **First CE Program Planned:** It is required that applications be submitted at least ninety (90) days prior to your first CE offering under our accreditation. What is the date of your first planned CE event with accreditation from this board?

13. **Attendance Record:** It is required that program attendees are given some tangible record of their attendance at your CE program (*i.e. certificate, letter, etc.*). How will you provide this?

PLEASE ATTACH THE FOLLOWING INFORMATION WITH YOUR APPLICATION:

1. **Mission Statement:** Such statement should be related to Continuing Education for Social Workers, Clinical Social Workers, Marriage and Family Therapists and/or Mental Health Counselors to this application. Evidence that the leadership of your organization has reviewed and approved of this statement, in the form of appropriate signature(s) and date(s), is required. If you are applying to present CE as an individual, please write your own such statement. Such a statement should be in the format of a brief paragraph or two covering the organization and its educational goal(s), the target audience(s), the anticipated number of presentations per year, and if possible, the expected educational outcome(s).

2. **Table of Organization:** The table should highlight the relationship of CE coordinator(s) or provider(s) to your organization's leadership. Again, if you are an individual applying to present CE, simply state this on the form.

APPLICATION AFFIRMATION

I hereby swear and affirm, under penalties of perjury that the statements made on this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct any person, firm, officer, corporation, association, organization, or institution to release to the Professional Licensing Agency, or the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board, any files, documents, records, or other information pertaining to the named individual or organization requested by the Agency or the Board or any of their authorized representatives, in connection with processing this application for approval for approval of an organization to provide Continuing Education courses.

I hereby release the aforementioned persons, firms, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board to disclose to the aforementioned organizations, persons, and institutions, any information which is material to this application, and I hereby specifically release the Agency, and the Board, from any and all liability in connection with such disclosures.

I also agree to periodic state monitoring of our programs at the discretion of the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear and affirm that I have read the above statements and agree to the same.

Signature of applicant	Date signed (*month, day, year*)